STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED 01/15/2013		
	PROVIDER OR SUPPLIE ROOK REHABILITA	R .TION & SKILLED NURSING CEN	TER	3811 P	ARNELL AVE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0000	and State Lice conducted by Department of accordance will Survey Date: Facility Number Provider Number: Surveyor: Am Code Specialis At this Life Sat Glenbrook Rel Nursing Center compliance will Participation in Medicare/Med Subpart 483.7 from Fire and the National F Association (National F	th 42 CFR 483.70(a). O1/15/13 er: 000092 per: 155176 100266090 y Kelley, Life Safety t fety Code survey, habilitation & Skilled r was found not in th Requirements for n icaid, 42 CFR O(a), Life Safety the 2000 edition of ire Protection FPA) 101, Life Safety hapter 19, Existing ccupancies and 410	KOO	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000092

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		INSTRUCTION 01	(X3) DATE S COMPL		
	or condition	155176	A. BUI B. WIN	LDING		01/15/	
NAME OF B	AD OVADED OD CLIDDI IED		B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER	FORT V	VAYNE, IN 46805		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	Type V (000) c	onstruction and was					
	fully sprinklere	d. The facility has					
	a fire alarm sys	stem with smoke					
	detection in th	e corridors and					
	areas open to t						
		ed smoke detectors					
		alled in the resident					
		cility has a capacity					
		a census of 72 at					
	the time of this	s survey.					
	All areas where	e the residents have					
		ess are sprinkered.					
		ding facility services					
	are sprinklered	*					
	Administrator's						
		- 4 - 4 - 10 - 0					
		Robert Booher, Life Safety dical Surveyor on 01/22/13.					
	Code Specialist We	dicui buiveyor on on 22/13.					
	The facility was	s found not in					
	compliance wit	th the					
	aforementione	d regulatory					
	requirements a	is evidenced by the					
	following:						

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Event ID: SHG921

Facility ID: 000092

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155176	B. WIN			01/15/	2013
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018	NFPA 101 LIFE SAFETY CO	DDE STANDARD					
SS=E		corridor openings in other					
		closures of vertical					
	•	or hazardous areas are					
	substantial doors	, such as those constructed					
		oonded core wood, or					
		ng fire for at least 20					
		n sprinklered buildings are esist the passage of					
		no impediment to the					
		ors. Doors are provided					
		able for keeping the door					
		ors meeting 19.3.6.3.6 are					
	permitted. 19.3	3.6.3					
		prohibited by CMS					
	_	health care facilities.	17.00	110			02/02/2012
	Based on obse		K00	018	1. The therapy door has had a		02/03/2013
	interview, the f				latch placed on the door. 2. All corridor doors have been		
	ensure 1 of 1 T				reviewed for appropriate latching		
	corridor door s	ets closed and			doors. All residents have the		
	latched into the	e door frame. This			potential to be affected.		
	deficient practi	ce could affect			3. The Maintenance Director		
	residents in the	e Therapy room			was educated by the Executive		
	which has a ca	pacity of 5			Director on 1/28/13 that all doors		
	residents.				installed in corridor spaces will have		
					positive latches. The Maintenance Director will check corridors monthly	W	
	Findings includ	le·			that positive latching hardware is in	у	
					place and latching properly.		
	Based on obse	rvation and			Maintenance Director will report		
		the Maintenance			findings to CQI committee for		
	Director on 01				appropriate follow up. If 100%		
		wledged the double			threshold is not met and action plan		
	corridor doors		1		will be developed. Feb 3 rd 2013		
		were not equipped					
	with positive la	tching hardware.					

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Event ID: SHG921

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155176	B. WIN			01/15/	/2013
NAME OF D	ROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	ΓER	FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3.1-19(b)						
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SHG921

Facility ID: 000092

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155176	B. WIN			01/15/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			3811 P	ARNELL AVE		
GLENBR		TION & SKILLED NURSING CENT	ER	FORT V	WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG K0038	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=E	LIFE SAFETY CO	ODE STANDARD					
33-L		anged so that exits are					
		e at all times in accordance					
	with section 7.1.	19.2.1					
	1. Based on ob		K00	38	1. The identified corridor doors		02/03/2013
	interview, the f	acility failed to			were addressed to ensure proper		
	ensure 2 of 7 e	xit doors were			function on January 22 nd by IEI. The identified door lock to the bathroom		
	accessible. He	alth care			was flipped so that the lock was on	ļ	
	occupancies pe	ermit			the inside of the bathroom.		
	delayed-egress	s locks if all the			2. All corridor exits were		
	conditions of L	SC, Section			reviewed for proper function. Also		
	7.2.1.6.1 are m	net. LSC 7.2.1.6(c)			all bathroom doors were reviewed		
	requires an irre	eversible process			for locks. All residents have the		
	<u>-</u>	e lock within 15			potential to be affected. 3. The Maintenance Director		
	seconds upon a	application of a			was educated by the Executive		
	-	ease device. This			Director on 1/28/13 that all exit		
		ce could affect 12			doors need to release appropriately		
	=	e 300 hall and any			and that locks on any resident area		
		f and residents in			was be installed in a way not to lock		
	the Administra				a resident in. All exit doors will be checked for proper release monthly		
	the Administra	tion nam.			with every fire drill. If any further		
	Findings includ	lo:			locks are installed to resident		
	Tillulligs illelad	ie.			bathroom the Administrator will		
	Pacad on obser	cyation with the			make a second inspection upon		
		rvation with the			completion to ensure resident		
	Maintenance D				safety. Maintenance Director will		
		1 1:45 p.m. to 1:55			report findings to CQI committee for appropriate follow up. If 100%	r	
	•	nall north exit door			threshold is not met and action plan		
		stration hall exit			will be developed.		
		ere equipped with			4. Feb 3 rd 2013		
	electromagneti	c locks, would not					
	release after pu	ushing the door for					
	15 seconds. W	hen tested by the					
	Maintenance D	irector at the time					
			1				

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Event ID: SHG921

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A DATE SURVEY COMPLETED					
AND FLAN	OF CORRECTION	155176		LDING	<u> </u>	01/15/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	NTER	FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		s, he acknowledged					
		eleased after 30					
	seconds.						
	3.1-19(b)						
	2. Based on ol	bservation and					
	interview, the f	facility failed to					
		t egress path from 1					
		room restrooms					
	was readily accessible at all times.						
	This deficient practice could affect 2 of 72 residents.						
	2 01 72 1031401						
	Findings includ	de:					
	Based on obse	rvation and					
		the Maintenance					
		/15/13 at 12:45					
		owledged the door estroom door of					
	resident room						
		e outside requiring					
	a tool to open	the door from in					
	the restroom.						
	3.1-19(b)						
	5.1 15(b)						

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Event ID: SHG921

Facility ID: 000092

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01	COMPLETED
155176 B. WING	01/15/2013
STREET ADDRESS, CITY, STATE, ZIP COI	DE
NAME OF PROVIDER OR SUPPLIER 3811 PARNELL AVE	
GLENBROOK REHABILITATION & SKILLED NURSING CENTER FORT WAYNE, IN 46805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP	PROPRIATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
K0056 NFPA 101 SS=D LIFE SAFETY CODE STANDARD	
If there is an automatic sprinkler system, it is	
installed in accordance with NFPA 13,	
Standard for the Installation of Sprinkler	
Systems, to provide complete coverage for	
all portions of the building. The system is	
properly maintained in accordance with NFPA 25, Standard for the Inspection,	
Testing, and Maintenance of Water-Based	
Fire Protection Systems. It is fully	
supervised. There is a reliable, adequate	
water supply for the system. Required	
sprinkler systems are equipped with water	
flow and tamper switches, which are	
electrically connected to the building fire alarm system. 19.3.5	
Based on observation and K0056 1. On January 24 th a spr	rinkler $02/03/2013$
interview, the facility failed to head was installed in the	
ensure complete automatic Admistrator's closet.	
sprinkler system was provided for 2. PIPE and the maintena	
1 of 1 closets in the further areas were identified.	
Administrator's office in 3. PIPE will continue to n	nonitor
accordance with NFPA 13, sprinkler heads biannually in	the
Standard for the Installation of facility. Maintenance Director	
Sprinkler Systems, to provide report findings to CQI commi	
complete coverage for all portions appropriate follow up. If 1009 threshold is not met and active.	
of the building. This deficient will be developed.	στι ριατί
practice could affect 1 or possibly 4. Feb 3 rd 2013	
2 residents in the Administrator's	
office.	
office.	
Findings include:	
Based on an observation and	
interview with the Maintenance	
Director on 01/15/13 at 2:46	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176			NSTRUCTION 01	(X3) DATE : COMPL 01/15/	ETED	
	PROVIDER OR SUPPLIER OOK REHABILITATION & SKILLED NURSING CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	III PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE	
				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .		

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Event ID: SHG921

Facility ID: 000092

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155176	A. BUII B. WIN			01/15/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0062	NFPA 101						
SS=F	LIFE SAFETY CO						
	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5						
	Based on observation and		K00	62	1. All identified gauges were		02/03/2013
	interview, the facility failed to				replaced on January 24 th by S&S		
	ensure 5 of 6 s	prinkler gauges			2. There are no other gauges in	n	
	were tested every five years. NFPA 25, Section 2–3.2 states gauges shall be replaced every five years				the facility. All residents have the potential to be affected.		
					3. The Maintenance Director		
					was educated by the Executive		
	or tested every				Director on 1/28/13 that gauges		
	comparison wit	•			need calibrated or replaced every 5		
		eficient practice			years. PIPE will be reviewing the		
	could affect all	•			identified gauges annually for		
	could affect all	occupants.			appropriate calibration or change		
					every 5 years. Maintenance Directo	r	
	Findings includ	ie:			will report findings to CQI committee for appropriate follow		
					up. If 100% threshold is not met and	d	
		rvation with the			action plan will be developed.		
	Maintenance D	irector on			4. Feb 3 rd 2013		
	01/15/13 at 1:	-					
	sprinkler gauge	es had a					
	manufacture da	ate of 2007. Based					
	on an interview	wwith the					
	Maintenance D	irector at 2:58 p.m.					
		conference, he was					
	_	ide documentation					
	=	sprinkler gauges					
		rated or replaced.					
	nad been callb	rated of replaced.					
	3.1-19(b)						
	J.1-13(U)						
I			1		i		

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Event ID: SHG921

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155176	B. WING			01/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER	FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0064 SS=E	NFPA 101 LIFE SAFETY CO	DDE STANDARD					
33-E		iguishers are provided in all					
		pancies in accordance with					
	9.7.4.1. 19.3.5.						
	Based on obse	rvation and	K00	64	1. The identified fire		02/03/2013
	interview, the f	acility failed to			extinguisher was lowered.		
	ensure 1 of 1 la	aundry room			2. All remaining fire		
	portable fire ex	ctinguishers was			extinguishers were checked for proper placement. All residents have	۵	
	mounted so the	e top of the			the potential to be affected.		
	extinguisher w	as no more than			3. The Maintenance Director		
	five feet (60 in	ches) above the			was educated by the Executive		
	floor. NFPA 10), Section 1–6.10			Director on 1/28/13 that all fire		
		ctinguishers having			extinguishers need to be placed no		
	=	not exceeding 40			more than 5 feet off the ground.		
	_	e installed so the			During monthly fire extinguishers checks will ensure proper height of		
	•	extinguisher is not			all fire extinguishers. Maintenance		
	more than 5 fe	-			Director will report findings to CQI		
		This deficient			committee for appropriate follow		
					up. If 100% threshold is not met and	l	
	•	affect 20 residents			action plan will be developed.		
		I in the event of an			4. Feb 3 rd 2013		
		uiring evacuation					
	through the se	rvices hall.					
	Findings includ	le:					
	_						
		rvation with the					
	Maintenance D	irector on					
	01/15/13 at 2:	:08 p.m., the fire					
	extinguisher m	ounted on the wall					
	in the folding r	oom of the laundry					
		five feet ten inches					
		to the top of the					
		er. Measurements					
	The extinguism	er. Measurements					

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PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED 01/15/2013				ETED	
		155176	B. WIN			01/15/	2013
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
CI ENDD		TION & SKILLED NURSING CENT	ED		ARNELL AVE VAYNE, IN 46805		
			EK		VATNE, IN 40000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	COMPLETION DATE
1710				mo	<u> </u>		DATE
	Director.	by the Maintenance					
	Director.						
	3.1-19(b)						
	3.1-19(0)						

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Event ID: SHG921

Facility ID: 000092

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn	01	COMPLE	ETED
		155176	A. BUIL			01/15/2	2013
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER	FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0069	NFPA 101						
SS=E	LIFE SAFETY CO	DDE STANDARD					
	Cooking facilities	are protected in					
	accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and						
			K00	69	1. The identified filters were		02/03/2013
	interview, the f	acility failed to			changed for the proper filters		
	ensure 2 of 9 filters in the kitchen hood system were baffle filters.				2. There are no other hoods. A	II	
					residents have the potential to be affected.		
	NFPA 96, the S	tandard for			3. The Maintenance Director		
	Ventilation Cor	ntrol and Fire			was educated by the Executive		
	Protection of Commercial Cooking				Director on 1/28/13 that hood must	t	
	Operations, Sec	ction 3.1 states			have appropriate filters placed.		
	mesh filter sha	ll not be used. This			These filters will be checked with		
		ce could affect any			routine required inspections by		
	•	dining room with a			Degreasing Engineers of the hood system. Maintenance Director will		
		east 20 residents	report findings to CQI committee for		nr.		
					appropriate follow up. If 100%	"	
	and kitchen sta	aff in the event of			threshold is not met and action plan	,	
	an emergency.				will be developed.		
					4. Feb 3 rd 2013		
	Finding include	2:					
	Based on obse	rvation of the					
	kitchen hood s	ystem with the					
	Maintenance D	•					
		:06 p.m., two mesh					
	= =	re in use. This was					
	acknowledged	by the Maintenance					
	Director at the	time of					
	observation.						
	3.1-19(b)						
	3.1 13(6)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. Building 01		COMPL	COMPLETED	
	155176		B. WIN			01/15/	2013
NAME OF B	DOMDED OD CHINDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				3811 P	ARNELL AVE		
GLENBR	OOK REHABILITAT	TION & SKILLED NURSING CEN	ΓER	FORT \	WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0144 SS=F	NFPA 101	ODE STANDARD					
33-1	LIFE SAFETY CODE STANDARD Generators are inspected weekly and						
		oad for 30 minutes per					
		nce with NFPA 99.	77.01				
	3.4.4.1.						02/02/2012
	Based on recor		K01	44	1. The generator was tested and		02/03/2013
	interview, the f				held the required load on January 28 th 2013		
	maintain a com	•			2. The records for 2013 are up		
		hly generator load			to date. All residents have the		
	testing for 3 of				potential to be affected.		
		ter 3–4.4.1.1 of			3. The Maintenance Director		
	-	es monthly testing			was educated by the Executive		
	of the generato	or serving the			Director on 1/28/13 that the generator must have a documented		
	emergency elec	ctrical system to be			load test monthly. The Executive		
	in accordance v	with NFPA 110, the			Director will review the		
	Standard for Er	nergency and			documentation monthly for 3		
	Standby Powers	s Systems, chapter			months to ensure consistent		
	6-4.2. Chapte	r 6–4.2 of NFPA			recordings of the load tests. If 100%		
	110 requires g	enerator sets in			compliance the Executive Director will check quarterly for 6 months.		
	Level 1 and Lev	vel 2 service to be			Maintenance Director will report		
	exercised unde	er operating			findings to CQI committee for		
	conditions or n	ot less than 30			appropriate follow up. If 100%		
	percent of the	EPS nameplate			threshold is not met and action plan		
	rating, at least	monthly, for a			will be developed. 4. Feb 3 rd 2013		
	minimum of 30) minutes. Chapter			4. FED 3 IU 2013		
	3-5.4.2 of NFP	A 99 requires a					
	written record	of inspection,					
	performance, e	exercising period,					
	and repairs for	the generator to be					
		ained and available					
	-	by the authority					
		tion. This deficient					
		affect all occupants.					
	-	•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/15/2013		
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE TER FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	Findings include:						
	Based on record review of the generator "Weekly Exercise/Monthly Load Test Log" with the Maintenance Director on 01/15/13 at 11:35 a.m., a monthly load test was not conducted for the months of April, May and September of 2012. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review. 3.1–19(b)						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01 COMPL			ETED	
		155176	B. WING		01/15/	2013	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
GLENBROOK REHABILITATION & SKILLED NURSING CENT			3811 PARNELL AVE FER FORT WAYNE, IN 46805				
GLENBR	OOK KEHABILITA	HON & SKILLED NORSING CENT	LIX	FORT	WATNE, IN 40805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0147	NFPA 101						
SS=D	LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National						
	Electrical Code. 9		17.0.1	4.77			00/05/0010
	Based on obser		K0147		Both identified cords where		02/05/2013
	interview, the f		1		removed.		
	ensure 2 of 2 f	lexible cords were			2. An audit was conducted		
	not used as a s	ubstitute for fixed			through the facility and no further		
	wiring to provi	de power for			cords were identified. All residents have the potential to be affected.		
	•	nent or equipment			Maintenance will conduct		
					rounds monthly to ensure all high		
	with a high current draw. NFPA				current and medical equipment are		
		ectrical Code, 1999			plugged in correctly Staff		
	Edition, Article 400–8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed				Development will educate staff on		
					the proper use of extension cords or	า	
					February 5 th 2013. Maintenance		
					Director will report findings to CQI		
	wiring of a stru				committee for appropriate follow		
	_				up. If 100% threshold is not met and	l	
	=	ce could affect 2 of			action plan will be developed.		
	72 residents ar	nd any number of			4. Feb 5th 2013		
	staff.						
	Findings include:						
	a. Based on ob	convation and					
		the Maintenance					
	Director on 01,	/15/13 at 12:55					
	p.m., he acknow	wledged a					
	refrigerator wa	s supplied					
	-	n extension cord					
	power strip in t						
	-						
	medication roo						
	b. Based on observation and						
interview with the Maintenance							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176			MULTIPLE CO TLDING NG	01	COMPL 01/15	ETED
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CEN		TER	3811 PA	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE WAYNE, IN 46805	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Director on 01/15/13 at 1:30 p.m., he acknowledged a concentrator was supplied electricity by an extension cord power strip in resident room 227. 3.1–19(b)					

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